PRINTED: 01/16/2013 FORM APPROVED

Indiana State Department of Health

| OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |   | (X3) DATE SURVEY COMPLETED  12/13/2012   |   |
|---|--|--|---|---|--|---|
|   |  |  |   |   |  |   |
| NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  1701 N SENATE BLVD INDIANAPOLIS, IN 46206   |   |   |  |   |
|   |  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |  | (X5)<br>COMPLETE<br>DATE  |
| This visit was for the complaint.  Complaint: IN001090 Unsubstantiated, lack Date of Survey: 12-1  Facility number: 005  Surveyor: John Lee, Public Health Nurse Surveyor: Indiana University Health 1AC 15-1.5-5, Mean 15-1.5-6, Nursing ser Surgical services, Ho | investigation of a State 877 k of sufficient evidence. 13-12 051 R.N. Surveyor ealth is in compliance wedical staff, 410 IAC rvice, and 410 IAC 15-0spital Licensure Rules.  | ith<br>1.6-9,  | S 000   | DEFICIENCY)   |  |   |
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|   | ROVIDER OR SUPPLIER  UNIVERSITY HEALTH  SUMMARY ST (EACH DEFICIENC REGULATORY OR  INITIAL COMMENTS  This visit was for the complaint.  Complaint: IN001090 Unsubstantiated, laci  Date of Survey: 12-1  Facility number: 005  Surveyor: John Lee, Public Health Nurse:  Indiana University He 410 IAC 15-1.5-5, Me 15-1.5-6, Nursing sei Surgical services, Ho | O05051  ROVIDER OR SUPPLIER  UNIVERSITY HEALTH  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATI  INITIAL COMMENTS  This visit was for the investigation of a State complaint.  Complaint: IN00109877  Unsubstantiated, lack of sufficient evidence.  Date of Survey: 12-13-12  Facility number: 005051  Surveyor: John Lee, R.N. Public Health Nurse Surveyor  Indiana University Health is in compliance w 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-3 Surgical services, Hospital Licensure Rules.  QA: claughlin 12/28/12 | ROVIDER OR SUPPLIER UNIVERSITY HEALTH  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for the investigation of a State complaint.  Complaint: IN00109877 Unsubstantiated, lack of sufficient evidence.  Date of Survey: 12-13-12  Facility number: 005051  Surveyor: John Lee, R.N. Public Health Nurse Surveyor  Indiana University Health is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.6-9, Surgical services, Hospital Licensure Rules.  QA: claughlin 12/28/12 | ROVIDER OR SUPPLIER  UNIVERSITY HEALTH  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for the investigation of a State complaint:  Complaint: IN00109877  Unsubstantiated, lack of sufficient evidence.  Date of Survey: 12-13-12  Facility number: 005051  Surveyor: John Lee, R.N. Public Health Nurse Surveyor  Indiana University Health is in compliance with 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.6-9, Surgical services, Hospital Licensure Rules.  QA: claughlin 12/28/12 | TOURDER OR SUPPLIER  UNIVERSITY HEALTH  SUMMARY STATEMENT OF DEFICIENCIES  (RACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  S 0000  INITIAL COMMENTS  S 0000  INITIAL COMMENTS  This visit was for the investigation of a State complaint.  Complaint: IN00109877  Unsubstantiated, lack of sufficient evidence.  Date of Survey: 12-13-12  Facility number: 005051  Surveyor: John Lee, R.N.  Public Health Nurse Surveyor  Indiana University Health is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.6-9, Surgical services, Hospital Licensure Rules.  QA: claughlin 12/28/12 | TORNITICATION NUMBER    DOSOS1   STREETADDRESS, CITY, STATE, ZIP CODE |

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE